

Please Print Plainly
SHADED AREAS FOR
LAB USE ONLY

State of Washington
DEPARTMENT OF HEALTH
1610 N.E. 150th ST., Seattle, Washington 98155-7224

MYCOBACTERIOLOGY

13		COUNTY-CITY (8-10)		(11-14)		DATE SPECIMEN OBTAINED (15-20) MONTH DAY YEAR	
DATE RECEIVED (21-26)	REASON(27)	SEX (28) 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	AGE (29-30)	(31)	(32)	SPECIMEN: (31) <input type="checkbox"/> Sputum <input type="checkbox"/> Gastric <input type="checkbox"/> Urine <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Fluid..... <input type="checkbox"/> Tissue..... <input type="checkbox"/> Other Source.....	
PATIENT'S NAME (Last)		(First)		(Initial)		Comments:.....	
ADDRESS		CITY		ZIP CODE		REFERENCE CULTURE ONLY	
MAIL RESULTS TO: →						Source	
ADDRESS: →						Date Inoc	
CITY: →				STATE WA	ZIP CODE		
AREA CODE AND PHONE NO. ()							

(DO NOT WRITE BELOW THIS LINE)

MICROSCOPIC REPORT
(Culture results to follow)

40
1 ☐ Unsatisfactory
2 ☐ Not Found
3 ☐ AFB Found (reference culture only)
☐ Found..... per.....
Comments (53): _____

CULTURE REPORT

1 ☐ Unsatisfactory
2 ☐ Negative at 8 weeks
☐ Acid-fast bacilli present _____ Date _____
Comments (54): _____

Date

Tested By:

Unit Head:

Tested By:

Unit Head:

DATE OF FINAL REPORT (75-80)